Assessing the Impact of Copayment on Family Planning Services: A Preliminary Analysis in California

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Abstract: A legislatively mandated copayment system for California state-funded family planning services was evaluated after the first six months of experience. Most clients reportedly could make their payments, but three times as many providers suggested lowering the fees as suggested raising them, and one-third reported a decrease in client donations. While the majority of providers did not report a decrease in clients, 22 per cent did so. For these drop-outs, it is estimated that the State would pay approximately $3 million in costs associated with unintended pregnancies, or one and a half times the amount cut from the Family Planning budget. (*Am J Public Health* 1983; 73:763–765.)

Introduction

The general assumption about cost-sharing charges is that when such charges are levied, "unnecessary" demands for health care are reduced and fiscal savings are realized. These savings may not hold in preventive health care settings, however. A belt-tightening attempt by the California Legislature during budget hearings for the 1981/82 fiscal year made it necessary to reconsider the issue of copayment for health services, including the State's Family Planning Program. As an arbitrary starting place, the Assembly Ways and Means Subcommittee on Health proposed a budget reduction of $2 million, roughly 6 per cent of the contraceptive services component of the budget. An assumption that family planning services were being over-utilized as a basis for imposing copayment was never implied by the Legislature. In fact, they continued to support the need for family planning based on the documented unmet need for subsidized services.[1]

After preliminary hearings, legislation was passed in June 1981 requiring the Department of Health Services' Office of Family Planning (OFP) to institute a sliding fee copayment system for family planning services based on family size and income,[2] which was to be developed and implemented by July 1, 1981, a mere two weeks after the passage of the legislation. OFP's $41 million budget was then reduced by $2 million.

This paper provides a preliminary analysis of the effect of these actions on services after the first six months' experience.

The Copayment System

Prior to the copayment mandate, family planning services were provided free to all income-eligible persons by 183 providers at approximately 500 OFP-funded clinic sites. In 1981, clinics served an estimated 549,000 women; 475,000 of these women were eligible for OFP subsidized services because their family incomes were less than 80 per cent of the State's median income for families of comparable size.

With such a short time frame in which to carry out the mandate of the copayment legislation, little effort could be made to solicit comments and suggestions about the fees from family planning providers, the Department's Family Planning Advisory Board, or other interest groups who had contributed to earlier discussions. Moreover, questions about the administrative cost to providers of instituting a copayment system and the reasonableness of the fees had to wait for an answer until after the system was put into effect. No time was allowed to introduce the fee concept to family planning clients, most of whom were unaccustomed to paying for their clinic visits.

Data from the OFP's Statewide Family Planning Reporting System generated some of the patient profile information about family size and income that was used to develop the fee schedule.* Based on these estimates, sliding fees that appeared to be recoverable and could replace the $2 million budget reduction were assigned to contraceptive and sterilization services. For the former, the fees ranged up to $10, for the latter up to $20.

It was decided that it would be more manageable to charge clients for each visit rather than attempt to collect a larger fee from them at the initial or annual visits. Visits which were contraceptive supply refill visits only and included no other medical or counseling services were exempt from copayment as were all contraceptive-related complication visits paid for by OFP but provided to the client away from the clinic site.

The recovery of funds was dependent upon the provider agencies accurately reporting to the OFP the amount of copayment that the client was *expected* to pay. There was no provision in the legislation to exempt providers from the copayment mandate although some requested waivers. Nevertheless, clinics could exercise the option of not collecting the fee from the client. If they chose to absorb the cost, they had to reduce the amount they billed to OFP by the amount of the uncollected fees. All agencies were allowed a sum of $2 per visit to offset the cost of establishing and maintaining a fee collection system.

Agencies were not required to provide services if a client could not pay the copayment fee, but were strongly encouraged not to withhold services due to a client's inability to pay. Agencies were not allowed to raise the charges they billed to OFP because of uncollected fees.

Evaluation Methodology

The first six months of experience with copayment was chosen as the initial study period for two reasons: significant negative trends could be noted early and reversed by modifi-

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*Fee Schedule available on request to author.

TABLE 1—Distribution of Provider Agencies by Type and by Copayment Implementation Status

Type of provider	Total	Copayment Implementation Status		
		Implemented	Implemented Temporarily	Did Not Implement
Total	171	129	3	39
Community Clinic	72	61	2	9
County Health Department	39	29	1	9
Free Clinic	14	4	—	10
Hospital Outpatient Clinic	12	8	—	4
Planned Parenthood	18	15	—	3
Rural Health Clinic	11	10	—	1
Student Health Service	1	—	—	1
Other	4	2	—	2

TABLE 2—Number Responding and Per Cent Distribution by Type of Service and Change in Client Population

Type of Service	Number Responding	Change in Client Population	
		Decrease %	No Change %
Contraception	122	22	78
Pregnancy Testing	108	18	82
Female Sterilization	38	a	97
Male Sterilization	31	a	97

a) Only 1 agency reported a decrease
Note: Per Cents are calculated independently and may not add to totals.
Many providers gave data for both contraception and pregnancy testing services (and possibly for sterilizations as well) under contraception.

cation to the system; and, recommendations for change that required legislative action could be taken up in the Spring '82 budget hearings.

The OFP Statewide Reporting System could not be used to generate or substantiate required data quickly. The data collected from providers for this evaluation were rough estimates based on impressions, supported to some extent by in-house data or record-keeping systems. It is recognized that there are limitations to the validity of such data and that the initial conversion from a free to a fee paying system involved reaction to an adjustment period that may not hold over time.

Results

Of the 183 potential provider respondents, 171 (93 per cent) returned completed questionnaires. Collection of fees was implemented by 129 (75 per cent) of the responding providers (Table 1).

Of the 122 agencies who responded to a question on clinic attendance, 27 (22 per cent) reported a decrease for contraceptive services (Table 2). Twenty-four agencies who reported on the amount of decrease in client population for contraceptive services reported a median decrease of 14.5 per cent. The percentage change for each agency was weighted by the size of the agency to estimate the effect of the change statewide. The estimated population decrease in these agencies was 2.4 per cent of OFP-funded clients statewide. The reasons offered for the decreases were related primarily to clients' inability to pay the fees or client confusion about being asked to pay in a once free system.

Of the 119 agencies reporting collections for contraceptive visits, 38 (32 per cent) reported that there was less than 10 per cent difference between what should have been collected and what actually was collected. For each type of service—contraception, pregnancy testing, and sterilization—over one-half of the agencies reported collecting 80 per cent or more of the copayment fee.

Half of the agencies reported that less than 10 per cent of their contraceptive clients had difficulty paying their copayment fee. For other services, a higher percentage reported no client difficulty. When the client was unable to pay, about a third of the providers served the client and absorbed the loss of the fee.

Of the 103 providers who reported on changes in client donations to their agency, six reported an increase, and 33 reported a decrease.

Client willingness to return for follow-up visits such as pill refills or medically indicated visits such as repeat pap smears decreased according to 23 of the 96 agencies which reported on this item.

While providers made many recommendations for changes in the way copayment was administered, 36 (26 per cent) of the 138 responses to this question indicated that no changes should be made. The most frequently made recommendations were: coordinate the fee schedule with Title X guidelines**; abandon the copayment system; and, charge a flat fee. These suggestions were made by 12, 11 and 8 per cent, respectively, of the responding providers.

Discussion

Implementing a copayment system for family planning services in publicly funded clinics did not show marked deleterious effects on client services after six months of experience, perhaps because of the rather flexible implementation by the agencies. The imposition of the copayment system on the Family Planning Program and the $2 million budget cut, in fact, may have protected the program from further legislative cuts proposed in the subsequent year's budget hearings. The program recommended that until the State had additional experience with copayment, no legislative changes to the system should be made.

Caution must be exercised in interpreting California's experience. This was a preliminary assessment, and it is not known how these findings will hold over time. Providers often lacked data to respond to all questions, and the data may be biased by the omission of unknown information or by the influence of factors such as clinic outreach policies. Second, funding levels from other state and federal funding sources remained constant during this period and some provider agencies may have been able to replace OFP funds with other funds. Third, the assessed fees were modest and most agencies instituted lenient collection policies. Fourth, and most importantly, even though nearly all of the $2 million taken from the OFP budget was replaced by client-generated fees or the absorption of deficits by family planning agencies, and the State achieved an immediate $2 million savings, these savings may be illusory.

**Title X regulations prohibit collection of fees from clients who have family incomes less than 150 per cent of the poverty guidelines for families of their size. Because the OFP Copayment Fee Schedule was in conflict with these regulations, the OFP providers who received Title X family planning funds (approximately one-third of the providers) had to absorb the loss on an estimated 10 per cent of their clients who fell into this "conflict zone".

For every 100 women who drop out of the OFP program, there will be an estimated 21 unintended pregnancies in addition to the six which would have occurred even if the women had been enrolled at a family planning agency.[3] Based upon this estimated probability, even the small (2.4 per cent) reported reduction in women receiving services because of copayment could result in 2,402 unintended pregnancies this year. At an estimated cost to the State of $1,240 per pregnancy,[4] the total cost for these unintended pregnancies would be $2,978,000, or one and a half times what the State would have had to invest had it left the OFP budget intact.

REFERENCES

1. Office of Family Planning, California Department of Health Services: Women in Need and Women Provided Subsidized Family Planning Services, Annual Statistical Report, 1979 & 1980, Sacramento.
2. California Welfare and Institutions Code, Sect. 14501.5, Stats 1981.
3. Okada L, Gillespie D: Impact of Family Planning Programs on Unplanned Pregnancies. Fam Plann Perspectives 1977; 9:173–176.
4. California Department of Health Services: Benefits and Cost of the Family Planning Program, February, 1981, Sacramento.

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ERRATUM

In: Spitz AM, et al: Third-trimester induced abortion in Georgia, 1979 and 1980. Am J Public Health 1983; 73:594–595.

On page 594, Methods section, first paragraph, second sentence should read: "Although the DHR has defined the third trimester as the period at ≥27 weeks' gestation and the American College of Obstetricians and Gynecologists has defined it as the period at ≥29 weeks' gestation, for this study we defined it as the period at ≥25 weeks' gestation.[3,4]"

On page 595, Results section, penultimate paragraph, last sentence, should read: "One report was due to a recording error."

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